APPENDIX B

TEMPORARY DETENTION ORDERS

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TEMPORARY DETENTION ORDERS (TDOS):

General Information

The 1995 Virginia General Assembly directed the Department of Medical Assistance Services, (DMAS) to process all requests for payment of services rendered as a result of Civil/Criminal Mental Temporary Detention Orders (TDO) effective July 1, 1995, issued pursuant to section 37.1-67.1 of the Code of Virginia.

Any magistrate may, upon the advice of, and only after an in-person evaluation by the local community services board or their designee, issue an order for temporary detention if it appears from all evidence readily available that the person is mentally ill and in need of hospitalization and that the person presents imminent danger to self or others as a result of mental illness, or is so seriously mentally ill as to be substantially unable to care for self, and the person is incapable of volunteering or unwilling to volunteer for treatment. A law-enforcement officer executes Temporary Detention Orders.

The employee of the community services board or its designee shall determine the facility of temporary detention for all individuals. The detention order may include transportation of the person to such other medical facility as may be necessary to obtain **emergency medical evaluation or treatment** prior to the detention placement. Medical screening provided through the emergency rooms are not covered unless there is documented evidence that there may be an underlying medical condition affecting the physical or mental health of the person.

The duration of temporary detention shall not exceed 48 hours prior to a hearing. If the forty-eight-hour period herein specified terminates on a Saturday, Sunday, or a legal holiday, such person may be detained until the next work day which is not a Saturday, Sunday, or legal holiday, but in no event may be detained longer than 96 hours.

Claims Processing

Hospitals and physicians must submit claims to DMAS for services rendered to patients as a result of the issuance by a court. Charges must be submitted on a UB-92 (CMS -1540) claim form or CMS-1500 (12-90) claim form. DMAS will accept only the original claim forms. Photocopies or laser-printed copies will not be accepted because the individual signing the forms is attesting to the statements made on the reverse side of the forms. These statements become part of the original billing invoice.

All TDO claims must have the TDO form attached to the claim with the pre-printed case identification number. Failure to provide the TDO form will result in claims being returned to the provider for incomplete information. The Execution section on the TDO form must be signed by the law enforcement officer and dated to be valid.

Processing of TDO claims includes both Medicaid-eligible and non-Medicaid-eligible patients. TDO is the payer of last resort and attempts must always be made to first bill the primary carrier, including Medicaid, prior to billing TDO exception for the State and Local Hospital Program (SLH). The actual processing of the TDO claim will be processed by our fiscal agent, First Health Service.

Each claim will be researched for coverage by any other resource. If the patient has other resources, the claim will be returned to the provider. When claims are returned to the provider, there will be an attached letter advising the provider to bill the other available payment resource.

Mail all TDO claims to:

Department of Medical Assistance Services
TDO - Payment Processing Unit
600 East. Broad Street, Suite 1300
Richmond, Virginia 23219

Reimbursement

Payments for services rendered will be paid at the Medicaid allowable reimbursement rates established by the Board of Medical Assistance Services.

Weekly remittance advice will be sent by our fiscal agent beginning with claims post marked on or after July 1, 2003. The remittance voucher will be mailed each Friday and the reimbursement check will be attached.

Make inquires related to the TDO claims processing, coverage, or reimbursement to:

Hospital inquiries to (804) 786-2620
All other provider inquiries to (804) 786-0821

Health Maintenance Organizations (HMOs)

Per the contract with DMAS, Virginia Medicaid's HMOs must pay for services provided under TDOs to Medicaid enrollees even if the services are provided outside of the HMO's network. However, the provider is to follow the billing instructions of the HMO.

UB-92 BILLING INSTRUCTIONS

Instructions for Completing the UB-92 CMS-1450 Universal Claim Form

The UB-92 CMS-1450 is a universally accepted claim form that is required when billing DMAS for covered services. This form is readily available from printers. The UB-92 CMS-1450 **will not** be provided by DMAS.

General Information

The following information applies to Temporary Detention Order claims submitted by the provider on the UB-92 CMS-1450:

All dates used on the UB-92 CMS-1450 must be two digits each for the day, the month, and the year (e.g., 070100) with the exception of Locator 14, Patient Birthdate, which requires four digits for the year.

NOTE: NO SLASHES, DASHES, OR SPACES.

Where there are A, B, and C lines, complete all the A lines, then all the B lines, and finally the C lines. Do not complete A, B, C, and then another set of A, B, C.

When coding ICD-9-CM diagnostic and procedure codes, do not include the decimal point. The use of the decimal point may be misinterpreted in claims processing.

Continue to submit outpatient laboratory charges on the CMS-1500 (12-90) billing form as required by Medicaid. These charges will only be reimbursed if done in conjunction with an Emergency Room visit outside of the facility providing inpatient hospital care. Emergency Room services must be included on the inpatient hospital invoice if the same facility provides both services. Emergency Room services are not covered for medical screenings.

To adjust or void a claim submitted on or after July 1, 2003:

To adjust a previously paid claim, complete the UB-92 CMS-1450 to reflect the proper conditions, services, and charges. In addition, in Locator 4 (Type of Bill) enter code 117 for inpatient hospital services or code 137 for outpatient services, and in Locator 37, enter the 9-16 digit Internal control number (reference number) of the original paid claim. Enter an explanation for the adjustment in Remarks, Locator 84.

To void a previously paid claim, complete the UB-92 CMS-1450 to reflect the proper conditions, services, and charges. In addition, in Locator 4 (Type of Bill) enter code 118 for inpatient hospital services or code 138 for outpatient services, and in Locator 37, enter the 9-16 digit Internal control number (reference number) of the original paid claim. Enter an explanation for the adjustment in Remarks, Locator 84.

The professional fee is not a reportable item on the UB-92 CMS-1450 for general or psychiatric hospitals (inpatient or outpatient). The professional components must be billed utilizing the CMS-1500 (12-90) billing form.

UB-92 Invoice Instructions

The following description outlines the process for completing the UB-92 CMS - 1450. It includes Temporary Detention Order (TDO) specific information and must be used to supplement the material included in the *State UB-92 Manual*.

Locator		Instructions
1	**Required**	Enter the provider's name, address, and telephone number.
2	Unlabeled Field	
3	**Required (if applicable)**	**PATIENT CONTROL NO.**—TDO will accept an account number which does not exceed 17 alphanumeric characters.
4	**Required**	**TYPE OF BILL**— Enter the code as appropriate. For billing on the UB-92 CMS -1450, the only valid codes for TDO are: 111 Original Inpatient Hospital Invoice 117 Adjustment Inpatient Hospital Invoice 118 Void Inpatient Hospital Invoice (effective 07/01/03) 131 Original Outpatient Invoice 137 Adjustment Outpatient Invoice 138 Void Outpatient Hospital Invoice (effective 07/01/03)
5	**Required**	**FED. TAX NO.—**Enter the number assigned to the provider by the federal government for tax reporting purposes. This is known as the tax identification number (TIN) or employer identification number (EIN).
6	**Required**	**STATEMENT COVERS PERIOD**—Enter the beginning and ending service dates reflecting the ACTUAL time span for the TDO. Use both "from" and "to" for a single day. The billing period may overlap calendar months as long as it does not cross over the Commonwealth of Virginia's fiscal year end. Claims submitted outside of the TDO time span will be returned to the provider.

7	**Required**	**COV D. (Covered Days)**—Enter the total number of TDO covered days as applicable.
8	**Required**	**N-CD. (Non-Covered Days)**—Enter the total days of care not covered by TDO for the inpatient hospitalization. Non-covered days are not included in the covered days.
9	Not required	C-ID. (Coinsurance Days)
10	Not required	L-RD. (Lifetime Reserve Days)
11	Unlabeled Field	
12	**Required**	**PATIENT NAME**—Enter the patient's name—last, first, middle initial.
13	**Required (if known)**	**PATIENT ADDRESS**—Enter the patient's address.
14	**Required (if known)**	**BIRTHDATE**—Enter the month, date, and full year (MMDDYYYY).
15	**Required**	**SEX**—Enter the sex of the patient as recorded at the date of admission, outpatient service, or start of care.
16	Optional	MS (Patient's Marital Status)
17	**Required**	**ADMISSION**—Enter the date of admission for inpatient. Enter the date of service for outpatient.
18	**Required**	**HR (Admission Hour)**—Enter the hour during which the patient was admitted for inpatient or outpatient care.
19	**Required**	**TYPE (Type of Admission)**—For inpatient services only, enter the appropriate code of "1."
20	**Required**	**SRC (Source of Admission)**—Enter the appropriate code of “8” for the source of this admission. Code "8" is for Court/Law enforcement.
21	**Required**	**D HR (Discharge Hour)**—Enter the hour the patient appeared at the Involuntary Detention Hearing.

22 **Required** — **STAT (Patient Status)**—Enter the status code as of the ending date in the Statement Covers Period (Locator 6). (If the patient was a one-day stay, enter code "01.")

- 01 Discharged to home or self-care
- 02 Discharged/transferred to another short- term general hospital for inpatient care
- 05 Discharged/transferred to another type of institution for inpatient care or referred for outpatient services at another institution
- 20 Expired
- 30 Still a patient Code "01" discharged is to be used when the patient remains in the hospital after the TDO hearing.

23 **Required (if applicable)** — **MEDICAL RECORD NO.**—Enter the number assigned to the patient's medical/health record by the provider for history audits. NOTE: Do not substitute this number for the Patient Control Number (Loc. 3) which is assigned by the provider to facilitate retrieval of the individual financial record.

24-30 Not required — **CONDITION CODES**—Enter the code(s) in numerical sequence (starting with 01) which identify the conditions relating to this bill that may affect payer processing.

31 Unlabeled Field

32-35 Not Required — **OCCURRENCE CODES AND DATES—**Enter the code(s) in numerical sequence (starting with 01) and the associated date to define a significant event relating to this bill that may affect payer processing.

36 Not Required — **OCCURRENCE SPAN CODES AND DATES**—Enter the code(s) and related dates that identify an event relating to the payment of this claim.

37 **REQUIRED (if applicable)** — **INTERNAL CONTROL NUMBER (ICN) DOCUMENT CONTROL NUMBER (DCN)**—Enter the 16 digit reference number of the paid claim to be adjusted or voided. A brief explanation of the reason for the adjustment is required in Locator 84 (Remarks).

NOTE:
A = Primary Payer
B = Secondary Payer

C = Tertiary Payer

Cross Reference to the Payer Identification in Locator 50 A, B, C (Payer Identification).

38 Optional **RESPONSIBLE PARTY NAME AND ADDRESS**

39-41 **Required** **VALUE CODES AND AMOUNTS**—Enter the appropriate code(s) to relate amounts or values to identified data elements necessary to process this claim.

One of the following codes **must** be used:

82 No Other Coverage
83 Billed and Paid
85 Billed and Not Paid

Other additional codes may be used if applicable.

42 **Required** **REV. CD. (Revenue Codes)—**Enter the appropriate revenue code(s) which identify a specific accommodation, ancillary service, or billing calculation.
Code = 4 digits, right justified, leading zeros.

The State UB-92 Manual provides revenue code details. **The following information supplements the State UB-92 Manual and lists the specific NON-COVERED revenue codes for TDO. See the approved revenue code listing for hospitals in the "Exhibits" section.**

11 X Room and Board - Private (Medical or General)
5 Hospice

12 X Room and Board - Semi-Private Two Beds (Medical or General)
5 Hospice

13 X Semi-Private Three to Four Beds
5 Hospice

14 X Private (Deluxe)

15 X Room and Board Ward (Medical or General)
5 Hospice

17X Nursery

18 X Leave of Absence

22 X Special Charges

23 X Incremental Nursing Charge Rate
- 5 Hospice

25 X Pharmacy
- 4 Drugs Incident to Other Diagnostic Services
- 6 Experimental Drugs

26 X IV Therapy
- 2 IV Therapy/Pharmacy Services
- 3 IV Therapy/Drug/Supply Delivery
- 4 IV Therapy/Supplies

27 X Medical/Surgical Supplies and Devices
- 3 Take Home Supplies
- 4 Prosthetic/Orthotic Devices
- 6 Intraocular Lens
- 7 Oxygen—Take Home
- 8 Other Implants

28 X Oncology Not covered

29 X Durable Medical Equipment (other than rental)
- 2 Purchase of new DME
- 3 Purchase of used DME
- 4 Supplies/Drugs for DME Effectiveness (Home Health Agency only)

30 X Laboratory
- 3 Renal Patient (Home)

32 X Radiology - Diagnostic
- 1 Angiocardiography
- 2 Arthrography
- 3 Arteriography

33 X Radiology - Therapeutic
- 1 Chemotherapy - Injected
- 2 Chemotherapy - Oral
- 3 Radiation Therapy
- 4 Chemotherapy - IV

36 X Operating Room Services
- 2 Organ Transplant - other than kidney
- 7 Kidney Transplant

37 X Anesthesia
- 4 Acupuncture

40 X Other Imaging Services
- 3 Screening Mammography
- 4 Positive Emission Tomography

41 X Respiratory Services
- 3 Hyperbaric Oxygen Therapy

42 X Physical Therapy
- 1 Visit Charge
- 2 Hourly Charge
- 3 Group Rate

43 X Occupational Therapy
- 1 Visit Charge
- 2 Hourly Charge
- 3 Group Rate

44 X Speech-Language Pathology
- 1 Visit Charge
- 2 Hourly Charge
- 3 Group Rate

47 X Audiology

48 X Cardiology
- 1 Cardiac Cath Lab

49 X Ambulatory Surgical Center

50 X Outpatient Services

51 X Clinic

52 X Free-Standing Clinic

53 X Osteopathic Services

54 X	Ambulance—**Covered only** for transfers to or from a psychiatric or general acute care facility to another psychiatric or general acute care facility. Documentation must support a medical condition that prevents transport by law enforcement personnel.
55 X	Skilled Nursing
56 X	Medical Social Services
57 X	Home Health Aide (Home Health)
58 X	Other Visits (Home Health)
59 X	Units of Service (Home Health)
60 X	Oxygen (Home Health)
64 X	Home IV Therapy Services
65 X	Hospice Service
66 X	Respite Care (HHA Only)
76 X	Treatment/Observation Room
79 X	Lithotripsy
81 X	Organ Acquisition
82 X	Hemodialysis - Outpatient or Home
83 X	Peritoneal Dialysis - Outpatient or Home
84 X	Continuous Ambulatory Peritoneal Dialysis - Outpatient or Home
85 X	Continuous Cycling Peritoneal Dialysis - Outpatient or Home
88 X	Miscellaneous Dialysis
89 X	Other Donor Bank

90 X Psychiatric/Psychological Treatments
- 2 Milieu Therapy - Not Covered
- 3 Play Therapy - Not Covered

91 X Psychiatric/Psychological Services
- 1 Rehabilitation - Not Covered
- 2 Day Care - Not Covered
- 3 Night Care - Not Covered
- 7 Bio Feedback
- 8 Testing

92 X Other Diagnostic Services
- 1 Peripheral Vascular Lab
- 2 Electromyelogram
- 3 Pap Smear
- 4 Allergy Test

94 X Other Therapeutic Services
- 1 Recreational Therapy
- 2 Educational Training
- 3 Cardiac Rehabilitation
- 4 Drug Rehabilitation
- 5 Alcohol Rehabilitation
- 6 Complex Medical Equipment - Routine
- 7 Complex Medical Equipment - Ancillary

96 X Professional Fees - Not Covered

97 X Professional Fees (Extension of 96 X)

98 X Professional Fees (Extension of 96 X and 97 X)

99 X Patient Convenience Items
All are Non-Covered **except** 997 (Admission Kits)

43 **Required** **DESCRIPTION**—Enter the National Uniform Billing Committee (NUBC) description and abbreviation (refer to the *State UB-92 Manual*).

44	**Required (if applicable)**	**HCPCS/RATES** Inpatient: Enter the accommodation rate. Outpatient: Enter the applicable HCPCS code.
45	Not Required	SERV. DATE—Enter the date the service was provided.
46	**Required**	**SERV. UNITS** Inpatient: Enter the total number of covered accommodation days or auxiliary units of service where appropriate. Outpatient: Enter the one unit of service for services in the Emergency Room **(1 visit = 1 unit).**
47	**Required**	**TOTAL CHARGES (by Revenue Codes)**—Enter the total charge(s) pertaining to the related revenue code for the current billing period. Total charges must include only covered charges for the TDO time period. Note: Use revenue code "0001" for TOTAL.
48	Optional	**NON-COVERED CHARGES**—Reflects the non-covered charges for the primary payer pertaining to the related revenue code. Note: Use revenue code "0001" for TOTAL Non-Covered Charges. (Enter the grand total for both total covered and non-covered charges on the same line of revenue code "0001.")
49	Unlabeled Field	
50	**A-C Required**	**PAYER**—Identifies each payer organization from which the provider may expect some payment for the bill. A = Enter the primary payer. B = Enter the secondary payer if applicable. C = Enter the tertiary payer if applicable. When TDO is the only payer, enter "TDO" on Line A. If TDO is the secondary or tertiary payer, enter on Lines B or C.

51 **A-C Required** **PROVIDER NO.**—The Medicaid Provider number assigned is to be entered on the appropriate line.

A = Primary
B = Secondary
C = Tertiary

52 A-C Not Required REL INFO (Release Information)—Certification Indicator

53 A-C Not Required ASG BEN (Assignment of Benefits)—Certification Indicator

54 **A, B, C, P Required (if applicable)** **PRIOR PAYMENTS (Payers and Patients)**
The amount the hospital has received by the indicated payer toward the payment of this bill prior to the billing date

Note: A = Primary
B = Secondary
C = Tertiary
P = Due from Patient

55 **Required (if applicable A, B, C)** **EST AMOUNT DUE**—Enter the amount estimated by the facility to be due from TDO less prior payment.

56 Unlabeled Field

57 Unlabeled Field

58 **A-C Required** **INSURED'S NAME**—Enter the name of the insured person covered by the payer in Locator 50. The name on the TDO line must correspond with the name on the TDO form. If the patient is covered by other insurance, the name must be the same as on the patient's health insurance card.

Enter the insured's name used by the primary payer identified on Line A, Locator 50.

Enter the insured's name used by the secondary payer identified on Line B, Locator 50.

Enter the insured's name used by the tertiary payer identified on Line C, Locator 50.

59 **A-C Required (if applicable)** **P. REL**—Enter the code indicating the relationship to the patient. Refer to the *State UB-92 Manual* for the codes.

A = Primary
B = Secondary
C = Tertiary

60 **A-C Required** **CERT.-SSN-HIC.-ID NO.**—For lines A-C, enter the unique ID # assigned by the payer organization shown on Lines A-C, Locator 58. DMAS staff will enter the enrollee's ID # after eligibility has been determined.

61 **A-C Required (if applicable)** **GROUP NAME**—Enter the name of the group or plan through which the insurance is provided.

62 **A-C Required (if applicable)** **INSURANCE GROUP NO.**—Enter the ID #, control #, or code assigned by the carrier/administrator to identify the group.

63 **REQUIRED** **TREATMENT AUTHORIZATION CODES**—Enter the number indicating that the treatment is authorized by the payer. This will be the actual TDO number on the form.

64 Not Required **ESC (Employment Status Code)—**Enter the code used to define the employment status of the individual identified in Locator 58.

65 Not Required **EMPLOYER NAME**—Enter the name of the employer that provides health care coverage for the insured individual identified in Locator 58.

66 Not Required **EMPLOYER LOCATION**—Enter the specific location of the employer in Locator 65.

67 **Required** **PRIN. DIAG. CD.**—Enter the ICD-9-CM diagnosis code that describes the principal diagnosis.

DO NOT USE DECIMALS.

68-75 **Required (if applicable)** **Other Diagnosis Code(s)**—Enter the codes for diagnoses other than principal if any.

DO NOT USE DECIMALS.

76 **Required** **ADM. DIAG. CD.**—Enter the ICD-9-CM diagnosis code provided at admission as stated by the physician.

77 Not Required **E-CODE** (External Cause of Injury Code)

78 Unlabeled Field

79 **Required** **P.C. (Procedure Coding Method Used)**—Enter the code identifying the coding method used in Locators 80 and 81 as follows:

5 - HCPCS
9 - ICD-9-CM

80 **Required (if applicable)** **PRINCIPAL PROCEDURE CODE AND DATE**—Enter the ICD-9-CM procedure code for the major procedure performed during the billing period. **DO NOT USE DECIMALS**. A procedure code must appear in this locator when revenue codes 360-369 or Codes 420-429, 430-439, and 440-449 (if covered by TDO) are used in Locator 42 or the claim will be rejected. For revenue codes other than those identified above used in Locator 42, the claims will not be rejected due to the lack of a procedure code in this locator. Use procedure code 8905 for TDO if the locator is left blank.

81 **A-E Required (if applicable)** **OTHER PROCEDURE CODES & DATES**—Enter the code(s) identifying all significant procedures other than the principal procedure (and the dates) on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal.

DO NOT USE DECIMALS

82 **Required** **ATTENDING PHYS. ID.**

Inpatient: Enter the Provider's Medicaid provider number for the physician attending the patient.

Outpatient: Enter the Provider's Medicaid provider number for the physician who performs the principal procedure.

83A Not Required **OTHER PHYS. ID**.

84 **Required (if Applicable)** **REMARKS**—Enter a brief description of the reason for the submission of the adjustment. Also, if there is a delay in filing, indicate the reason for the delay here and include any attachment to support the delay in timely filing. Also, provide any other information necessary to adjudicate the claim.

85 **Required** **PROVIDER REPRESENTATIVE**—Enter the authorized signature indicating that the information entered on the face of this bill is in conformance with the certifications on the back of the bill.

86 **Required** **DATE**—Enter the date on which the bill is submitted to TDO.